DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

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MEDICAID STEP-BY-STEP

BEFORE YOU APPLY

1. **Consider your options**—you may be able to protect your assets or avoid depending on Medicaid altogether through the purchase of certain long-term care insurance. See "2010 Montana Long-Term Care Rate Comparison Guide" (http://sao.mt.gov/consumers/2010LTCRateGuide.pdf) for more information about the cost of nursing home care and to learn about Long-Term Care Partnerships.
2. **Talk to your local Office of Public Assistance (OPA) for a pre-application screening.** The workers at the OPA are there to help the public! If you go in ahead of your application and speak to a case worker, he or she can give you information about the process and help you begin to gather the information you will need BEFORE you need it. This will help you avoid delays when the time comes to apply and streamline the eligibility process.
3. If you feel that you may need Medicaid's help to cover the costs of nursing home care, **contact your local Office of Public Assistance** (OPA) AS SOON AS POSSIBLE to speak to a case manager and begin filling out an application

APPLYING FOR MEDICAID

1. **Fill out an application**—applications are available at any Office of Public Assistance (OPA), and you do not need an appointment to pick one up. If you are unable to visit an office, call and they will send you an application in the mail or on the Internet at http://dphhs.mt.gov/publicassistance/hcs250.pdf. In addition, most long-term care facilities have application forms and can help you when you are applying.
2. **Turn in the first page of your application** at the OPA or by mail. If you are found eligible for Medicaid coverage, the date on your application will determine the start date of the coverage. You do not need an appointment to turn in the application.
   ****** On the application, you may list an authorized representative who will be able to assist with the application process. This may be a family member, a social worker, a family friend, a power of attorney, or some other person.
3. **Contact your local OPA** to make an appointment for an interview. If you are unable to interview in person, a phone interview can be schedule. While interviews are not required for eligibility purposes, they allow us to share program information with you and let you to ask any questions you may have and may help streamline the eligibility process.
4. **Bring you completed application and any documentation to your interview.** It is important that you complete your application as much as possible before your interview to prevent any delays. It is also important to report EVERYTHING, even if you have been told it "won't count." This allows the case manager to make a correct assessment the FIRST time, and, again, prevents

delays in processing. If you need help knowing what documentation you will need, ask your case manager, contact your OPA, or see "Helpful Hints When Applying for Medicaid for Nursing Home Care." Even if you do not yet have all documentation gathered, bring what you have and attend the interview.

5. **Respond to any requests for information on or before due dates!** After your interview, you may receive requests from your case manager for more information or documents. These notices will include the name of the applicant and list any information still needed.
6. **Request time** to gather any additional documents you may need. You will be given 10 days in order to gather new documentation. If you need more time, however, your manager will give you extensions. It is important to communicate with your case manager to prevent your case being denied. Please keep in mind that while extensions are sometimes necessary, the longer your case manager waits for your documentation, the longer it will take to process your application!

IF YOU ARE APPROVED

1. You will be **informed of your approval** for Medicaid by mail. The notice you receive will include the name of the recipient, the date Medicaid coverage will start, and the amount (if any) that the recipient will be expected to pay towards his or her care.
2. Keep in mind that Medicaid is determined on a month-to-month basis. If there are any changes in a recipient's income or resources, it is important to **notify your case** manager as soon as possible, but not later than ten days from the date you learn of the change.
3. "**Redetermination**" is a review of a recipient's Medicaid coverage which occurs at least once a year. You will be sent a yellow Medicaid Eligibility Renewal/Review form in the mail which MUST be filled out and returned to the OPA with proof of any new/changed information (bank statements, proof of income, etc.) in order for coverage to continue.

IF YOU ARE DENIED

1. You will be **informed of your denial** in the mail. Your denial letter will include your name and the reason for denial.
2. If you feel that you were denied coverage in error, you may **request a fair hearing**. There is a fair hearing form on the back of each notice you will receive. This is something you would fill out only if benefits have been closed, reduced or denied and you wish to appeal the action.

This information is current as of 9/1/2010. Medicaid policies can and do change, and it is the responsibility of the facility and applicant to verify the most current policies when working towards establishing Medicaid eligibility.